MEDICARE MODERNIZATION ACT: A LEGISLATIVE PRIMER

A Report Prepared for the

Legislative Finance Committee

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INTRODUCTION

The federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was signed into law in December 2003. The most significant change due to passage of the MMA is the addition of Part D, an outpatient prescription drug benefit for Medicare beneficiaries. Despite state and federal implementation issues, the availability of an outpatient drug benefit is a significant benefit for Medicare beneficiaries.[1]

The focus of this report is to inform legislators about the state government fiscal and public policy issues that they may deal with in the upcoming 2005 legislative session. Discussion of state issues is not intended to diminish the importance of a Medicare prescription drug for individual Medicare beneficiaries generally. Nor should issues raised in this report be extrapolated as comments regarding impacts on individual beneficiaries.

The Legislative Finance Committee (LFC) heard a report at its March meeting about the transition period from the effective date of the MMA until the implementation of the Part D benefit effective January 1, 2006. This report focuses on the impact of MMA on states, both in imposition of new state administrative duties and costs as well as relief from certain state Medicaid costs and federal payments to qualified state health plans that provide prescription drug coverage for retirees.

To date, there are many undefined aspects of the MMA, including the underlying data needed to calculate the fiscal effects. If more detailed financial and policy information is available, this "primer" on emerging state issues will be followed by a second report at the November LFC meeting.

HIGHLIGHTS OF IMPACTS TO STATES

The major state fiscal and public policy issues reviewed in this primer are:

- General fund savings due to federal assumption of prescription costs for some Medicare eligible persons currently receiving Medicaid or Mental Health Services Plan (MHSP) prescription drug benefits
- General fund cost of state payments to the federal government for the Medicaid drug cost savings (the "clawback")
- Increased Medicaid costs due to new enrollees discovered during Part D outreach (the "wood work effect")
- General fund costs if the state opts to provide a "wrap around" benefit for potential or known Medicare prescription coverage gaps
- Administrative and workload impacts to provide low-income eligibility determination, beneficiary education, grievance resolution, and coordination with the Social Security Administration
- Potential for federal reimbursement of 28 percent of allowable costs for state health plan insurance coverage for drugs for Medicare eligible employees and retirees

[1] Jeff Buska, Senior Medicaid Policy Analyst, Director's Office, DPHHS, personal conversation, September 21, 2004.

COST SAVINGS

The MMA expanded Medicare to provide an outpatient drug benefit to Medicare beneficiaries – including those who are also eligible for Medicaid prescription drug coverage (full benefit dual eligibles)[2]. Effective January 1, 2006, the act also prohibits federal financial participation for Medicaid outpatient drug costs for full benefit dual eligible Medicare beneficiaries. The exception to that prohibition occurs when state Medicaid plans covers drugs are excluded for reimbursement by Medicare Part D (e.g. over the counter drugs that are equivalent substitutes for prescribed drugs).

The Montana Medicaid program includes coverage for outpatient prescription drugs, which is an optional Medicaid service. Total prescription costs for the Medicaid program are estimated to be about $76 million in FY 2004.[3] About 50 to 52 percent of prescription drug costs paid by Montana are for full benefit dual eligibles. Too many unknowns exist to even "guesstimate" what the potential savings could be. However, those cost savings will be offset by general fund cost increases that also cannot be quantified at this point.

Some persons eligible for the state funded MHSP[4] are also eligible for Medicare. An important component of MHSP is payment for prescription drugs to treat mental illness. If such drugs are covered under the Medicare drug plan that a Medicare-MHSP eligible recipient chooses, there could also be savings in MHSP.

During the 2005 biennium, costs for MHSP prescription services are funded from a one-time diversion of tobacco settlement revenue. The Department of Public Health and Human Services (DPHHS) has indicated it will request that the legislature continue the diversion and that the funds be used for MHSP prescription costs as well as for matching funds for a proposed Medicaid waiver as part of the Medicaid redesign process. Information is not available at this point to project potential cost savings if the legislature continues the MHSP program at the FY 2004 level.

THE CLAWBACK

The MMA requires that states make payments to the federal government (a clawback) to offset Medicaid program cost savings and help cover the cost of Part D for full benefit dual eligibles. The clawback will be based on an average per person Medicaid drug cost for full benefit dual eligibles in calendar year 2003. The base year per person cost will be inflated forward from 2003 by a national rate established by the federal Centers for Medicare and Medicaid Services (CMS) and the clawback will be based on the inflated per person cost multiplied by the number of full benefit dual eligibles. States will pay 90 percent of the clawback amount beginning in 2006, with the percent declining to 75 percent over 10 years.

Some states have expressed concerns that the clawback will be higher than their share of Medicaid costs for full benefit dual eligibles because some states' pharmacy costs have grown at slower rates than

[2]Medicare is a federal health insurance program for people age 65 and older, for some people with disabilities and for some people with permanent kidney failure. Medicaid is a public health insurance program, jointly funded by state and federal governments, for low-income children and some of their parents, low-income persons age 65 and older, and some low-income disabled persons who meet federal Social Security Administration disability criteria. Some low-income aged and disabled persons are eligible for both Medicare and full Medicaid benefits, including prescription drug coverage.

[3] Duane Preshinger, Chief Acute Services Bureau, Health Resources Division, DPHHS, personal conversation, September 27, 2004. This cost is net of drug rebates, which average between 18 to 20 percent of total drug expenditures.

[4] In order to be eligible for MHSP a person must be diagnosed with a serious and disabling mental illness and must have an income below 150 percent of the federal poverty level ($18,735 annually for a two person household in 2004).

national inflation rates and because pharmacy cost saving measures implemented after the base year will not be reflected in clawback calculations.

The Montana Medicaid program is in the process of implementing a preferred drug list that is expected to yield cost savings that will not be included in the clawback. DPHHS is also in the initial stages of working with CMS to determine the number and cost of full benefit dual eligibles in 2003. Preliminary data estimates the number of full benefit dual eligibles between 17,000 to 20,000 of a total of about 110,000 Medicaid eligibles[5]. However, there is no per person cost data yet, so it is not possible to estimate a preliminary clawback amount at this time.[6]

The MMA establishes a cost ceiling for Medicare (45 percent of the U.S. Treasury). If future Medicare expenses exceed that ceiling, the clawback payments for states could be increased.[7]

WOOD WORK EFFECT

Some states are worried about the wood work effect – where Medicare Part D outreach identifies persons eligible for but not enrolled in Medicaid and then who subsequently enroll in Medicaid. This phenomenon has been apparent in other outreach efforts for new low-income programs in that existing programs experience increases in enrollment. The Congressional Budget Office estimates that the number of people eligible for the Medicare low-income benefit exceeds the number of dual eligibles in Medicaid today.[8] It is difficult to project Medicaid cost changes due to Part D outreach.

WRAP AROUND PROGRAMS

Some states have implemented state funded programs to pay for pharmacy costs not included in the Part D benefit for low-income beneficiaries, and for the "doughnut hole", where there is no federal assistance for pharmacy costs between $2,250 and $5,100 for beneficiaries with incomes above 150 percent of the federal poverty level. Wrap around programs must be supported entirely from state funds. The MMA eliminates the option for private sponsorship of prescription Medigap policies that would cover expenses not paid by Part D,[9] which may increase pressure for states to provide such coverage.

Medicare beneficiaries will choose among several different Medicare drug plans. At a minimum, each plan must include two drugs in each therapeutic class. If Medicare beneficiaries are unable to find one plan that would cover all medications that they are currently taking, they could be responsible for the cost of the drug(s) not covered or would need to switch to the covered drug. However, there are questions as to whether this process would allow persons to access such drugs.[10]

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[5] Buska, personal conversation, September 21, 2004.

[6] DPHHS received information about what drugs will be excluded from the calculation of per person costs during the week of September 20, 2004. Preshinger, personal conversation, September 27, 2004.

[7] Joy Johnson Wilson, Health Policy Director, National Conference of State Legislatures, National Web Seminar on the Medicare Modernization Act Sponsored by the National Conference of State Legislatures and National Governors Association, September 29, 2004.

[8] Brent Salo, National Governors Association, National Web Seminar on the Medicare Modernization Act Sponsored by the National Conference of State Legislatures and National Governors Association, May 4, 2004.

[9] Johnson Wilson, September 29, 2004.

[10] Beneficiaries have the right to appeal to a drug plan to provide a drug that is not included in the formulary. If the appeal were denied, then the beneficiary would need to pay the full cost of the drug or switch drugs. CMS representatives have requested state comments on whether this proposal will be effective. (Gale Arden, Director, Disabled Elderly Health Programs Group, Centers for Medicare and Medicaid Services, National Web Seminar on the Medicare Modernization Act Sponsored by the National Conference of State Legislatures and National Governors Association, September 29, 2004)

The legislature may see some requests for wrap around programs. For instance, if Medicare eligible MHSP beneficiaries would be unable to obtain needed psychotropic medications through the Part D benefit and they were unable to obtain effective medications, their illness could worsen. The fiscal issue in this scenario is that without appropriate medications, persons may decompensate and be committed to the Montana State Hospital potentially at a greater cost to the state than the cost of appropriate medications.

STATE WORKLOAD ISSUES

There are several managerial and administrative tasks that states must perform in order to meet MMA mandates. States must:

- Perform eligibility for Part D low-income subsidies and/or provide assistance to the federal Social Security Administration in doing so evaluation both income and resources
- Participate in a nation wide point of sale coordination of benefits between Medicare, Medicaid, and all private insurance payors to establish individual beneficiary co-payments and deductibles and to determine true out of pocket costs for Part D benefits[11]
- Periodically notify the federal CMS of the income level of low-income beneficiaries and when the beneficiaries move into an institution
- Assist CMS in the determination of the base year costs for the clawback
- Provide information and assistance to Medicare beneficiaries in the event of complaints or grievances

While draft rules have been issued by CMS, the Social Security Administration has not yet issued rules. Many of the requirements related to administrative tasks that states must perform are not yet clear. For instance, if the state must determine eligibility for low income beneficiaries, it is not known whether the state would accept a paper application and forward it to the Social Security Administration, or whether the state would be required to enter eligibility information in an automated system and make the determination. Even if states will not be required to perform eligibility, the MMA requires that states must be able to process Part D low-income eligibility as a condition of participating in the Medicaid program.[12]

States are waiting for information from the Social Security Administration about what will be required to determine eligibility for the subsidy. States have also not received direction about what will be required to transmit the information to CMS. DPHHS is in the process of developing an eligibility system that will have some capabilities related to the MMA. It seems logical to assume that the eligibility determination process must be fully functional in advance of in November 2005. Coordination with the Social Security Administration has not been clearly defined. States need to establish systems for exchanging information about who applied and the status of the application. States need to be working on systems changes now in order to be ready in time .[13]

[11] The national point of sale system will require participation by all pharmacies and all public and private insurance programs with a pharmacy benefit. It is unclear whether public or private entities or a partnership thereof will develop the system.
[12] Goyette, September 29, 2004.
[13] Nancy Atkins, Medicaid Director, West Virginia, National Web Seminar on the Medicare Modernization Act Sponsored by the National Conference of State Legislatures and National Governors Association, June 10, 2004.

It is not clear whether CMS will allow auto enrollment with an opt out feature for full benefit dual eligibles.[14] It is not clear when the first clawback payment must be made, and some of the variables to determine the clawback have not been specified.

FEDERAL REIMBURSEMENT FOR STATE EMPLOYEE HEALTH PLAN COSTS

Under the MMA states can be eligible for payments from the federal government if state employee health plans maintain prescription drug coverage for retired employees (payment of 28 percent of costs for a qualified plan). State plan coverage must be actuarially equivalent or better than Part D coverage and the reimbursable costs paid per retiree must be at least $250, but not greater than $5,000 per year.

The State of Montana public employee insurance program appears to meet the criteria for reimbursement in draft rules, notwithstanding completion of an actuarial analysis. The amount of payment will depend on whether retirees opt to maintain state health insurance coverage or opt for a Medicare plan. Once a retiree opts for Medicare prescription drug coverage, he may not re-enter the state plan.

CONCLUSION

The MMA initiates one of the most fundamental changes to Medicare in recent history – the addition of a prescription drug benefit. The Part D benefit will be implemented January 1, 2006, so MMA requirements for state administrative duties, payments for retiree coverage, and cost sharing will be effective for three quarters of the 2007 biennium. The 2005 legislature will deal with several impacts of the MMA that are common to all states. At this point, is not possible to tell whether Montana will experience a net gain or loss in general fund costs due to offsetting aspects of the MMA and it is not evident how fiscal and policy issues associated with the MMA will be addressed in the executive budget request or legislative package. Legislative staff will continue its research and analysis and provide updates to the LFC and to the 2005 legislature.

LFC REVIEW OF STAFF FOCUS

Staff will continue to research and analyze the state fiscal and policy issues related to the MMA. Staff will also provide an update at the November LFC meeting, and at that time might be able to provide more concrete options for consideration. However, LFC review of and comment on the following areas of staff focus would be greatly beneficial, especially if LFC members note interests that are not listed.

- How will the executive budget request deal with clawback payments, estimated Medicaid prescription drug savings, and potential federal reimbursement for qualified state employee health plan prescription drug costs?
- Will DPHHS make an estimate of the clawback prior to the beginning of the legislative session?
  - If not, why not?
  - If so, what type of limitations exist?
- If federal guidance regarding MMA is not final prior to a specified point in the legislative session and the legislature is interested in ensuring that fiscal or policy issues it considers important are enacted, what are options it can consider short of a special session?

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[14] CMS recently auto enrolled all low-income Medicare beneficiaries in a drug discount card because so few persons had opted to obtain the card. Source: "Low-Income Nonapplicants to Get Medicare Drug Cards", New York Times, September 23, 2004.